Consider It Done? The Likely Efficacy Of Mandates For Health Insurance

Mandates can be an effective tool in expanding health insurance coverage, but the devil is in the details.

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PROLOGUE: Massachusetts policymakers have painstakingly crafted interlocking health insurance initiatives and mandates, including an unprecedented individual mandate, in hopes of achieving near-universal coverage. Underscore "hopes," because predicting a target population's response to a mandate is, at best, an inexact science. As the first efforts to require motorcycle helmet use illustrate, a single miscalculation can doom an otherwise almost perfect mandate.

The 1966 National Highway Safety Act (NHSA) contained a proviso intended to reduce catastrophic head injuries from motorcycle accidents: States not requiring that all riders wear helmets would become ineligible for certain highway funds. By 1975, forty-seven states had universal helmet laws in place, compliance neared 100 percent, and the number of fatal head injuries plunged. Later that year, Congress voided the NHSA proviso. Helmet laws were quickly repealed or downgraded to less easily enforced partial-use laws in twenty-eight states; in those states, motorcycle accident deaths rebounded as helmet use fell to approximately 50 percent. Why the turnaround? For a vocal minority of riders, the perceived cost of compliance—loss of personal liberty—far exceeded the putative cost—the price of a helmet. Even as they donned helmets, antihelmet activists lobbied vigorously for repeal of the NHSA proviso and sued mandating states for infringing on their rights. They lost almost every constitutional challenge but succeeded in wearing down the states, and in winning Congress's sympathy.

Sherry Glied and colleagues identify three common attributes of highly successful mandates; one is an affordable cost of compliance. As we watch the Massachusetts experiment unfold and contemplate other large-scale health insurance mandates, these authors remind us to include all monetary costs in the "affordability" calculus. The early helmet laws remind us to include possible intangible costs, as well. Glied (sag1@columbia.edu) is professor and chair of the Department of Health Policy and Management, Mailman School of Public Health, at Columbia University, in New York City. Jacob Hartz is a medical student at the University of New Mexico in Albuquerque. Genessa Giorgi is earning her master of public health degree at the Mailman School.

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ABSTRACT: Several health insurance reform plans, including the recently enacted Massachusetts plan, envision the use of individual or employer mandates to increase coverage rates. In this paper we summarize and analyze existing evidence on the effectiveness of mandates, drawing on evidence both from health insurance and from other arenas where mandates are often used. We find that mandates can, but do not always, increase participation in programs. The effectiveness of a mandate depends critically on the cost of compliance, the penalties for noncompliance, and the timely enforcement of compliance. [*Health Affairs* 26, no. 6 (2007): 1612–1621; 10.1377/hlthaff.26.6.1612]

IN APRIL 2006, THE STATE OF MASSACHUSETTS passed a law requiring all state residents to hold health insurance or pay a penalty—legislation that is being treated as the nation's first individual insurance mandate. Other states, including Maryland, Maine, Washington, and California, have considered both individual and employer mandates as components of their health insurance expansion efforts, following the lead of Hawaii, which has had an employer mandate in place since 1977.[1]

Mandates, whether individual or employer, seek to compel people to offer or obtain health insurance that they would not otherwise voluntarily purchase or take up. Health insurance mandates are attractive to policymakers for several reasons. First, they offer a way to address the problem of those who are already eligible for public programs but fail to obtain coverage. Mandates can force this group to make obtaining health insurance a more urgent concern. Second, mandates can be seen as leveling the playing field, forcing employers or individuals who have been using publicly funded services to pay their fair share of the cost of coverage. Third, mandates can reduce the need for explicit public funding of new coverage, by substituting funds generated through the mandate for tax funds. Fourth, mandates can ease insurers' concerns that only less healthy people will choose to participate in a new voluntary insurance program, particularly if such a program incorporates controls on risk rating. Finally, mandates can act as a legislative self-control device, binding the government to provide adequate subsidies to make compliance feasible.

Policy analysts view mandates as a tool, not a panacea, and prior studies have discussed strategies for more effective design of mandates.[2] There is, however, little empirical information available to assess how effective mandates might be in practice. Experience with health insurance mandates is limited to the cases of Hawaii, with its employer mandate; Switzerland, where an individual mandate was implemented in 1996; and the Netherlands, which implemented a mandate as part of the reorganization of its health insurance system in 2005. Looking more broadly, however, mandates appear in many other social policy contexts. A review of the experience of mandates across a range of areas provides some useful evidence about what makes mandates more or less effective and what effect an individual mandate might be expected to have in a health insurance system.

An Overview Of Health Insurance Mandates

Governments routinely mandate that individuals, employers, and other levels of government behave in specific ways. Mandates offer governments a way to achieve policy goals without appropriating existing tax revenue. Despite mandates' ubiquity, however, the performance of mandates varies greatly, with compliance rates in the range of 30–99 percent (as we discuss below). We describe each of these mandates, and their enforcement, in turn.

■ **Hawaii.** Hawaii began mandating that certain employers purchase health insurance for their employees with the passage of the Prepaid Health Care Act in 1972. By 2002, 10.1 percent of Hawaiians lacked coverage, placing Hawaii eleventh among the states in insurance coverage. Analysis suggests that Hawaii's current relatively low rate of uninsurance can be attributed in part to the mandate and in part to the unique demographics of its population and its geographically isolated economy based on tourism and the military.[3] The mandate itself appears to have reduced uninsurance in Hawaii by a modest 5–8 percent. While uninsurance among those subject to the mandate has fallen, employment appears to have shifted toward sectors that are not subject to the mandate.[4]

Hawaii's mandate is enforced through random and routine audits, employee reports, and data matches. Data matching is facilitated by the fact that only a few large insurers operate in Hawaii. The penalty for noncompliance with the mandate is the greater of $25 per day or $1 per day for each employee out of compliance.

■ **Switzerland.** Switzerland introduced its individual mandate in 1994 with the passage of the Health Insurance Law (HIL), which became effective after being approved in a referendum in 1996.[5] Switzerland now enjoys near-universal coverage—but this reflects only a minute increase in coverage from the period before the mandate, when 98–100 percent of the population held coverage, most voluntarily.[6]

The Swiss health insurance mandate is enforced by the individual Swiss cantons using a comprehensive system of reporting combined with substantial penalties. Cantons are required to establish a mechanism for forcibly insuring those who do not voluntarily obtain coverage within three months of being born in or moving to Switzerland. Enforcement operates through a data match, combining information from unemployment insurance agencies, old-age insurance providers, and health insurance carriers. The match is facilitated by the existence of a single annual open enrollment period.[7] This means that at the end of that enrollment period, people's coverage is fixed for the coming year. Cantons may impose penalties of 30–50 percent above the premium on those who remain uninsured. Misrepresenting health insurance coverage is punishable by fines and prison terms.

■ **The Netherlands.** In 2005 the Netherlands shifted from a health insurance system in which 60 percent of the population received care through public sickness funds to a purely private health insurance system, with income-related subsidies and a risk-equalization program. All Dutch residents are mandated to purchase private health insurance (offered by competing for-profit providers). Those who do not

purchase coverage must pay a fine of 130 percent of the premium. As in Switzerland, there is a single annual open enrollment period. Formal enforcement has not yet begun, but initial estimates from a match of social insurance estimates from the first year of enrollment suggest that about 1.1 percent of Dutch residents—about 182,000 people—failed to enroll voluntarily in health insurance.[8]

Individual Mandates Outside Health Insurance

The effects of the Hawaiian, Swiss, and Dutch mandates on coverage were quite limited, largely reinforcing existing high levels of coverage. We turn now to mandates outside health insurance.

■ **Automobile insurance.** The most commonly cited example of an insurance mandate is the requirement that drivers hold liability insurance. As of 2006, forty-seven states and the District of Columbia mandated that all drivers hold such coverage. The percentage of motorists who lack coverage varies greatly from state to state, ranging from about 4 percent to 34 percent, according to a study by the Property Casualty Insurance Bureau.[9]

Penalties. Penalties for failure to comply with the liability insurance mandate vary widely from state to state, from no penalty at all, to fines of $50–$5,000, license suspension, impounding of vehicles, and jail time. In most states, no penalties are imposed for a first offense.[10] Enforcement of auto insurance mandates also varies. In some states, drivers must show proof of insurance when they register their automobile; in others, they must show proof of coverage if they are involved in an accident; and in others, they may be asked to produce proof of coverage at any time they are driving and are subject to random spot checks. States increasingly rely on electronic matching of insurance, registration, and license records to establish whether or not drivers hold mandated coverage.[11]

Efficacy. Surprisingly, the available evidence on the efficacy of mandates in automobile insurance in promoting liability coverage finds inconsistent results. A 1995 study, for example, contrasted the forty-seven states that had mandates to the three states without mandates and found that the average uninsured-motorist rate was actually lower in the states without mandates. In New Hampshire and Wisconsin, two of the states without mandates, the uninsured driver rates of 8 percent and 10 percent, respectively, were well below the national average.[12] A study of data for 1987 and 1992 found that mandates do reduce uninsurance but that their effects are much stronger if enforcement is stringent. Among states with mandates, those with higher fines tended to have higher compliance rates.[13]

■ **Child support.** Under Title IV-D of the Social Security Act, child support is collected from noncustodial parents. Enforcement operates through the Child Support Enforcement (CSE) program, a federal, state, and local partnership.

The program operates a computerized State and Federal Parent Locator Service (FPLS) to locate parents, their incomes, and their assets. This program gathers information on delinquent parents by accessing a wide range of public and private

records. Employers must report new hires, and financial institutions are required to provide a quarterly data match. In addition, parents may hire private collection agencies to enforce their rights. These agencies receive payment as a percentage of child support collected.[14]

Penalties. Noncompliance with the child-support mandate triggers a variety of penalties, including fines and back payments. Penalties may be imposed through the income tax system, by freezing bank accounts, or by placing liens on real or personal property. States can suspend or revoke drivers, professional, occupational, and recreational licenses if child support payments are in arrears. Jail is also an option for repeat offenders in some states (for example, Illinois).[15]

Compliance. Despite this elaborate structure of enforcement and penalties, compliance with child support is disappointingly low. Approximately 30 percent of mothers owed child support receive it.[16] Studies find that compliance with child support depends on income level and on the custodial parent's relationship with the noncustodial parent.

■ **Childhood immunization.** Since the early 1960s, American children have been required to be vaccinated against certain diseases before entering school or child care. States may choose which vaccines are required and may determine which factors generate exemptions (for medical, religious, and philosophical reasons).

Enforcement and penalties. The immunization mandate is enforced through the school's examination of a medical record. Most states require day, month, and year of vaccination and signature of a medical "witness." The penalty for noncompliance is typically through exclusion from school or a day care facility.[17]

Efficacy. Comparisons of states with and without immunization mandates for varicella suggest that mandates improve immunization rates. States with mandates averaged about an 85 percent immunization rate, while those without mandates averaged only a 77 percent rate.[18]

■ **Individual income tax.** Many health insurance mandate proposals envision enforcement through the income tax system. That tax is itself a mandate. The federal government and all but nine state governments levy income taxes on individuals; once each tax year, individuals have to report their earned income.[19] Often the tax is directly deducted from wages, dividends, annuities, and Social Security income, but individuals are still required to report the total values to the Internal Revenue Service (IRS). Self-employed people must tax their own wages for Social Security and Medicare at a rate of 15.3 percent (12.4 percent for Social Security and 2.9 percent for Medicare), which is similar to the amount withheld from most wage earners.[20] The IRS enforces compliance to the tax code by conducting random and systematic audits of high-wage earners and suspicious returns. Additionally, the IRS seeks out third-party reporting and informants.[21]

Penalties. The IRS enforces compliance to the income tax through three main penalties: the failure-to-file penalty, the failure-to-pay penalty, and tax fraud. The failure-to-file penalty is enforced if the tax return is not filed on time, and a pen-

alty of 5 percent of the tax owed is due for every month or partial month that the return is late. The penalty generally cannot exceed 25 percent of the total amount due. The failure-to-pay penalty is 0.5 percent of unpaid taxes each month after the due date, up to a maximum of 25 percent of the tax. Additionally, under certain circumstances, the IRS can criminally prosecute tax evaders. The penalty for tax fraud can be up to a five-year imprisonment and a $100,000 fine. However, these penalties are enforced sparingly even if the person is caught red-handed, thus weakening the penalty's deterrent capabilities.[22]

Compliance. With three levels of enforcement and high penalties, the IRS estimates that about 84.5 percent of people voluntarily file and pay the correct amount of income taxes they owe on time. About 80 percent of the noncompliance is attributable to underreporting the amount due, while only 20 percent is attributable to not filing or underpayment. Self-employed people account for the biggest percentage of noncompliers, partly because no third party is reporting their information to the IRS.[23] In 1998, noncompliance led to $232 billion in uncollected taxes.[24] Every year the IRS investigates about 4,000 cases, criminally prosecutes about half of those, and sentences about 1,000 people to prison.[25] Yet criminal investigations are expensive, and from the 1970s to 2000s, the percentage of individual audits dropped from 2.15 percent to 0.58 percent, while business audits dropped from 4 percent to 1 percent.[26] Studies show that increasing the audit rate and monetary value of the penalty increases compliance, but at a decreasing rate.[27]

■ **Minimum wage laws.** The federal government, all but six states, and a few localities mandate that employers compensate their workers at a minimum wage. The federal minimum wage is part of the Fair Labor Standards Act (FLSA).

Enforcement. The Wage and Hour Division of the U.S. Department of Labor (DoL) enforces the federal minimum wage. The division conducts investigations and gathers data to determine compliance with the law. Individuals may also file private suits for back pay and damages under the law, but such a suit may be filed only if the employer has paid back wages or the DoL has also filed suit.[28] Additionally, businesses are required to maintain records on wages paid by all employees. There are, however, no penalties for failure to maintain records, even though such a failure may make it very difficult to enforce the law.[29] States may also impose additional reporting requirements, and when two laws apply, the law with a higher standard is enforced. Some states require contractors (or other third parties) in high-wage-violation sectors, such as garment production, to self-monitor their suppliers and report any abnormalities to the state board of labor.[30]

Penalties. Under federal law, businesses that fail to comply with the minimum wage are required to pay back wages. Those who are found to have violated the law "willfully" are also subject to criminal prosecution and fines of up to $10,000; they can also have their business licenses revoked.[31]

Compliance. Studies of the minimum wage find compliance rates of 65–75 percent, with much variation among industries.[32] Compliance is highest in states

with higher penalties and where there are systems of third-party reporting that supplement firms' own records.

Lessons From Mandates

Even for the government, saying something is not the same as doing something. As the examples above suggest, simply declaring that an action must occur does not mean that it will. But some mandates are clearly more successful than others.

■ **Affordability factor.** The first factor that appears important in ensuring compliance with a mandate is that the cost of compliance be affordable. Consumers' costs of compliance include direct financial costs as well as paperwork and time costs. Studies in automotive liability insurance, for example, document that the share of drivers who are uninsured rises as premiums rise and that 82 percent of those without liability insurance state that financial burden is the main barrier.[33]

Research on program participation strongly supports the hypothesis that consumers' costs of compliance are important.[34] Similarly, according to a Government Accountability Office (GAO) study on income tax compliance, providing support for individuals filing their taxes markedly increases the compliance rate.[35]

■ **Penalty size.** The flip side of the cost of compliance is the penalty for failure to comply. Compliance rises with penalties—but only up to a point. States with higher fines have higher compliance rates in automobile insurance. The substantial penalty of not permitting a child to enroll in school appears to contribute to high rates of compliance with vaccination mandates.[36]

Penalties that are too high, however, may become meaningless. For instance, in Louisiana, only 60 percent of impounded cars are ever claimed, which suggests that this penalty is ineffective in convincing people to comply with insurance laws.[37] Studies of car insurance find that the prospect of a jail sentences does encourage compliance, but longer jail sentences have no additional deterrent effect, because people do not believe that long sentences will be enforced.[38]

Penalties that are too low make noncompliance financially attractive. They may also make enforcement less thorough. Agencies responsible for enforcing a mandate are often judged on their dollar success in collections. Funds collected may also become a component of agency budgets. These financial arrangements give enforcement agencies an incentive to seek out those who are subject to, and likely to pay, the largest penalties. By contrast, the costs of enforcing small penalties may be greater than the value of the funds collected.

■ **Probability factor.** The magnitude of penalties may be less important than the probability that they will be imposed. The first step in enforcement is identifying those who fail to comply with a mandate. Enforcing agencies must collect data frequently and in a timely manner, especially for insurance mandates. As the Swiss case suggests, enforcement of a health insurance mandate is likely to be most successful if it occurs through data matching at the time of intended purchase of coverage. It is very difficult to enforce penalties once people are sick and need care. Likewise, ex

post enforcement of the mandate will not have the effect of ensuring that people have coverage in advance of becoming ill.

■ **Databases.** Electronic data capture requires a sizable up-front investment but often generates major improvements in compliance. Several states have implemented databases to match insurance and driving records, in an effort to improve automobile insurance compliance rates. Studies in Utah and Georgia suggest that the use of databases has dramatically reduced the number of uninsured motorists.[39] Electronic data capture, however, is not a sufficient strategy to keep uninsurance rates low. Colorado recently considered eliminating its electronic data capture system because it was ineffective.[40] The Insurance Research Council (IRC), a trade group that generally opposes reporting requirements for insurers, suggests that of the eighteen states with electronic reporting programs in place for five years or more between, only six showed improvements, while twelve showed an increase in the number of uninsured motorists. That study finds that successful states combine electronic reporting with appropriate follow-up and penalties.[41]

■ **Multiple data sources.** Some evidence suggests that collecting data from multiple sources to monitor compliance is more effective than relying on a single source. For example, studies of minimum wage compliance find that areas using multiple monitoring mechanisms had much higher compliance than did those using only a single monitoring strategy.[42] Also, data collected through third parties are often more reliable than data collected directly from those subject to the mandate. Compliance with income tax, for example, is nearly perfect for wage and salary employees who report through employers but quite low for the self-employed and those who earn cash and self-report their income.[43] Third-party verification has also been effective in detecting uninsured motorists.

■ **Random audits.** Random audits are an alternative to data collection and routine monitoring. However, they are resource-intensive and must occur frequently and be well targeted to be useful. Studies of income tax and child support compliance document that compliance rates decline as the frequency of audits falls.[44]

■ **Easy avoidance of penalties.** Compliance also depends on how easy it is to avoid the penalty. One way to avoid a penalty is to cancel an insurance policy after the requirement to document coverage has been met. For example, many states require proof of insurance before a driver can register a vehicle. However, people avoid this penalty by purchasing a policy, then cancelling it shortly after registering.[45]

OVERALL, OUR REVIEW SUGGESTS THAT COMPLIANCE with mandates can be quite low. In some cases, however, compliance is nearly perfect. High-compliance situations share several features: Compliance is easy and relatively inexpensive; penalties for noncompliance are stiff but not excessive; and enforcement is routine, appropriately timed, and frequent. Enforcement is simplified if all (or nearly all) of those subject to the mandate must purchase coverage at one specified time and if enforcement occurs concurrently with purchasing cover-

age. States contemplating the use of health insurance mandates should recognize that success will likely be determined by the processes governing compliance and enforcement that are established long after the legislation has passed.

Putting these often intrusive and costly pieces into place will require much political will. And even the best mandate is unlikely to affect the behavior of those who are transient and have few assets.[46] To reach them, health policymakers will need to go beyond a mandate and make coverage more nearly automatic.

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NOTES

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